STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155772	A. BUILDING 00 B. WING	05/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COBBLESTONE CROSSINGS HEALTH CAMPUS	1850 E HOWARD WAYNE DRIVE TERRE HAUTE, IN47802

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F0000	This visit was for a Recertification and State Licensure survey. This visit resulted in an extended survey-immediate jeopardy. Survey dates: May 4-10, 2011 Extended survey dates: May 11-13, 2011 Facility Number: 011906 Provider Number: 155772 AIM Number: 200912380 Survey Team: Laura Brashear, RN, TC 5/4-6, 9-13/11 Mary Weyls, RN, 5/4-7, 9-12/11 Teresa Buske, RN, 5/4-6, 8-13/11 Census Bed Type: SNF: 45	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Residential: 33 Total: 78 Census Payor Type: Medicare: 32 Other: 46 Total: 78 Sample: 12 Supplemental sample: 4 Residential sample: 4 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 5-18-11 Cathy Emswiller RN			

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F0164 SS=D	The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. Based on observation and record review, the facility failed to provide personal privacy to 2 of 9 residents in a sample of 12 observed being toileted or bathed in that Resident #24 was in view of their roommate while being	F0164	F164Residents #24 and #27 suffered no ill effects form he alleged deficient practice and through corrective action and inservicing will ensure residents privacy is maintained.Completion Date 6/12/11All residents have the potential to be affected therefore through alterations in provision of care and inservicing will ensure privacy is maintained.Completion Date 6/12/11Systemic change to ensure privacy is maintained	06/12/2011

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	toileted and Resident #27 was exposed to the hallway during a bed bath. Findings include: 1. On 5/6/11 at 10:00 a.m., CNAs #18 and #19 were observed to provide a bed bath to Resident #27. The resident was observed in the bed by the door to the hallway. The privacy curtain provided for the bed was not pulled during the bath, and the resident was completely exposed to the hallway during the bath.. The CNAs were observed to open the door and exit the room three times during the bath to obtain additional linens. The resident was not covered while waiting. A facility procedure titled		furing provision of care i to have the window binds shut as well as door and room curtain pulled around the resident and staff will be inserviced on interpretive guidelines as it relates to privacy.Completion Date 6/12/11DHS or designee will audit residents receiving care 3/day for 2 weeks, then daily for 2 week, then 3/week for 3 months, 1/week thereafter wth results being submitted to QA Committee monthly for 6 months and quarterly thereafter.	

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	"Bath (Bed) [no date] provided by the MDS [Minimum Data Set] coordinator on 5/12/11 at 11:50 a.m., included but was not limited to, "General Resident Rights Guidelines ...Screen and drape resident for maximum privacy." 2. On 5/11/11 at 12:00 p.m., CNA #11 assisted Resident #24 to the toilet in the bathroom of the resident's room. The resident was positioned in front of the toilet, slacks pulled down and assisted to sit. The bathroom door was wide open and the privacy curtain not pulled to prevent the resident's roommate, observed in bed, from being in full view of the resident. Documentation contained in the facility's "Resident			

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	Move-In Guide," reviewed on 5/13/11 at 1:00 p.m., included, but was not limited to, "You have the right to personal privacy. ...2. When you are undergoing an examination or treatment, the staff should conduct the examination and treatment in a manner that maintains the privacy of your body (i.e. room door should be closed, privacy curtain should be pulled around the bed, etc.)" 3.1-3(p)(4)			

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review, observation and interview, the facility failed to ensure all	F0225	Res. #42 was interviewed and investigation completed regarding the bruise that she was admitted with.Completion Date 6/12/11There were no other residents affected by the deficient	06/12/2011

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	alleged violations including injuries of unknown source were reported immediately to the Administrator for 1 of 1 residents identified with injury of unknown source e.g. a bruise in a sample of 12. (Resident # 42) Findings include: On 5/10/11 at 3:10 p.m. with LPN # 25 present, Resident #42 was observed to have a dark purple bruise with yellowing edges on her left posterior upper arm. Interview of LPN #25 on 5/10/11 at 3:10 p.m. indicated she was unaware of the bruise on the resident. Review of the clinical record of Resident #42 on 5/5/11 at 3:15		practice and through inservicing and provision of reporting instructions will ensure all injuries of unknown origin are reported th the administrator immediately and ISDH if necessary.Completion Date 6/12/11Management staff and all line staff inserviced regarding investigation procedures and requirements of reporting all injuries of unknown origin immediately to the administrator.Completion Date 6/12/11Systemic change is that when residents are admitted there will be a skin grid and in interdisciplinary review of any injury of unknown origin in order to begin investigation if necessary an meet reportable guidelines of administrator notification.Completion Date 6/12/11DHS/designee will review all I/A and skin grids daily to ensure timely notification to administrator and reporting to ISDH.ED will submit all reportables including injuries of unknown origin to QA Committee mothly for review of compliance with reporting requirements for 6 months and quarterly or review and further recommendations.	

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	p.m. indicated the resident was readmitted to the facility from the hospital on 4/26/11 with a bruise to the left upper arm. The resident had been admitted to the hospital on 4/18/11 from the facility. Interview of the Administrator and the Director of Nursing on 5/11/11 at 10 a.m. indicated they were not made aware of the bruise until 5/10/11 and an investigation was initiated. 3.1-28(c)			
F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review, observation and interview, the facility failed to implement	F0226	F226Res #42 was interviewed and investigation completed regarding the bruise that she was admitted withCompletion Date 6/12/11There were no other residents affected by the deficient	06/12/2011

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	written policies and procedures for all alleged violations of abuse including injuries of unknown source for 1 of 1 residents identified with an injury of unknown source, a bruise, in the sample of 12 in that the allegations were not reported immediately to the Administrator. (Resident #42) Findings include: On 5/10/11 at 3:10 p.m. with LPN # 25 present, Resident #42 was observed to have a dark purple bruise with yellowing edges on her left posterior upper arm. Interview of LPN #25 on 5/10/11 at 3:10 p.m. indicated she was unaware of the bruise on the resident.		practice and through inservicing and provision of reporting instructions will ensure all injuries of unknown origin are reported to administrator immediately and ISDH if necessary.Completion Date 6/12/11Management staff and all line staff inserviced regarding investigation procedures and requirements of reporting all injuries of unknown origin immediately to the administrator.Completion Date 6/12/11Systemic change is that when residents are admitted there will be a skin grid and interdisciplinary review of any injury of unknown origin in order to begin investigation if necessary and meet reportable guidelines of administrator notification.Completion Date 6/12/11DHS/designee will review all I/A and skin grids daily to ensure time notification to administrator and reporting to ISDH.ED will submit all reportables including injuries of unknown origin to QA committee monthly for review of compliance with reporting requirements for 6 monhs and quarterly review and further recommendations.	

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	Review of the clinical record of Resident #42 on 5/5/11 at 3:15 p.m. indicated the resident was readmitted to the facility from the hospital on 4/26/11 with the bruise to left upper arm. The resident had been admitted to the hospital on 4/18/11 from the facility. Interview of the Administrator and the Director of Nursing on 5/11/11 at 10 a.m. indicated they were unaware of the bruise to the resident's upper arm as well as how it occurred until 5/10/11 when an investigation was initiated. Review of facility's current policy and procedure titled "Standard : Topic: Prevention and Reporting of Suspected Resident Abuse and Neglect..." dated 01/06 on 5/11/11 at 11:25			

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	a.m. indicated "...c. The Shift Supervisor or Manager is identified as responsible for initiating and/or continuing the reporting process, as follows: IMMEDIATELY notify the Executive Director [Administrator], Director of Health Services or their designee... INJURIES OF UNKNOWN SOURCE-means an injury that occurs when both of the following conditions are met: The source of the injury is not observed by any person or the source of the injury could not be explained by the resident AND the injury is suspicious in nature because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time of			

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	the incidence of injuries over time...." Review of the facility's current policy and procedure titled "STANDARD : TOPIC : Accidents and Incidents; Reports, Investigations, Follow-up and Disposition" dated 01/06 on 5/11/11 at 11:25 a.m. indicated "...2. To assure that the definition of accident/incidents may include, but are not limited to the following: Unexplained bruises/all skin tears....Procedure: ...3. Unusual occurrences will be reported immediately to the Supervisor/Manager/Charge nurse on duty and an Accident/Incident Report completed. Occurrences where there is suspected mistreatment, neglect, abuse, or injuries of			

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	unknown origin will be immediately reported to the Director of Health Services [Director of Nursing] and Executive Director [Administrator]..." 3.1-28(a)			
F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, interview and record review the facility failed to ensure 1 of 3 residents reviewed, identified with loose stools, in a sample of 12 received services to maintain physical well-being in that Resident #10 received a medication for constipation during the time frame of having	F0309	F309Resident #1 still has Miralax on hold until antibiotic therapy for c-diff is complete.Completion Date 5/1/11All residents have the potential to be affected by the alleged deficient practice therefore they have been reviewed to ensure that routine stool softeners/laxatives are held and MD notified if there is loose stool or diarrhea.Completion Date 6/12/11Licensed nurses will be inserviced an prudent bowel management and requirements when holding meds. CNA's will be inserviced on the required communication to nurse of	06/12/2011

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	loose bowel movements, due to Clostridium Difficile. Findings include: During interview of LPN #15, on 5/4/11 at 12:05 p.m. the LPN identified Resident # 10, as having c-diff. Resident #10's clinical record was reviewed on 5/5/11 at 12:45 p.m. An original admission date was noted of 3/25/11, with a readmission date of 4/4/11. A nursing note, dated 3/29/11, indicated the resident was sent to the emergency room for respiratory problems. The nursing notes indicated the resident returned on 4/4/11.		loose/diarrhea stool.Completion Date 6/12/11Sysemic change will be the alteration of the assignment sheet to allow for communication of residents with loose/diarrhea stools at end of shift.Completion Date 6/12/11DHS/designee will audit bowel records, 24 hr. report, assignment sheets and med administration record daily to ensure compliance.Completion Date 6/12/11Results of audits will be forwarded to the QA Committee monthly for six months and quarterly thereafter with further suggestions/recommendations as deemed necessary by the committee.	

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	A physician telephone order was noted, dated 4/10/11, indicating "Obtain stool specimen related to frequent mucus foul smelling stool, send to [Lab] for testing c-diff." A laboratory report was noted, dated 4/11/11, indicating "clostridium difficile toxin A and/or B detected." A physician's telephone order, dated 4/11/11, indicated the resident was to receive "Flagyl (anti-fungal) 500 mg one BID [twice daily] X [times] three weeks." A May 2011 Medication Administration Record [MAR] indicated the resident received the Flagyl through May 1, 2011.			

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	A physician's telephone order was noted, indicating "Obtain 2 negative stool specimen [after] flagyl therapy." A laboratory form, dated 5/4/11, indicated the resident was "negative for Clostridium difficile Toxin A and B. Review of form titled "Resident BM Description", documentation indicated the resident had a loose stool on 4/29/11, 5/4/11, 5/5/11, and 5/8/11. A physician's order was noted, dated 4/6/11, indicating the resident was to receive "Miralax Powder 510 gm mix 17 gm (1 lidfull) in juice/water and give by mouth every day for constipation"			

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	An April 2001 MAR (medication administration record) was noted indicating the resident received "Miralax" (treatment for constipation) April 12th through the 23rd of 2011, April 25th through the 27th 2011 and April 29th and 30th 2011. LPN #15 documented 11 of 18 days as giving the Miralax. During interview of LPN #15 on 5/11/11, at 9:50 a.m., the LPN indicated she had given the Miralax. The LPN indicated during that time frame the resident was having diarrhea. A physician's order was noted, dated 5/1/11, indicated "Hold miralax q [every] a.m., RT [related to] C-diff."			

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	155772	A. BUILDING 00 B. WING	05/13/2011

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	On 5/5/11 at 11:30 a.m., CNA #'s 1 and 4 provided incontinence care to resident #9. The resident was observed with loose bowel movement. 3.1-37(a)			
F0315 SS=D	Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation and record review, the facility failed to maintain 1 of 3 indwelling Foley catheters in a manner to prevent urinary backflow or in contact with contaminated surfaces to prevent potential infection in a sample of 12. [Resident #25] Findings include:	F0315	F315Resident #25's current foley catheter needs have been shared with the staff that care for her to prevent urinary tract infections from backflow urine.Completion Date 6/12/11All residents with catheters have the potential to be affected by the alleged deficient practice and therefore through corrective actions will ensure services are provided to prevent urinary tract infections.Completion Date 6/12/11Systemic change includes placement of drainge bag in hoder at all times, placement of a drainage bag holder during transfers and during routine care procedures. All nursing staff will	06/12/2011

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	1. On 5/5/11 at 10:05 a.m., Resident #25 was observed to be given a bed bath. The resident was observed with an indwelling Foley catheter and for the drainage bag and tubing, containing cloudy, yellow, urine, to be positioned on top of the mattress, next to the resident, during the bath. CNA #5 was observed to be providing the care to the resident. CNA #5 was observed to exit the room, after completing the bath an returned with another CNA to assist in transferring the resident. The drainage bag remained on top of the mattress for a period of time greater than 20 minutes, before lowering it below bladder level when the resident was transferred.		be inserviced on above topicsCompletion Date 6/12/11DHS and/or designee will monitor compliance with audits of catheter bag placement and handling daily for 30 days and weekly thereafter.Results of audits will be forwarded to QA Committee monthly for 6 months and quarterly thereafter for suggestions/recommendations.	

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	2. On 5/6/11 at 11:10 a.m., Resident #25 was observed in bed, and to receive a treatment to open areas on the back by RN #7. The resident's Foley catheter, urinary drainage bag was observed, attached to the bed, and for the bottom of the drainage bag to be in contact with the carpeted floor. Resident #25's clinical record was reviewed on 5/5/11 at 11:25 a.m. The resident's diagnoses included, but was not limited to, breast cancer and Clostridium difficile. An initial Minimum Data Set [MDS] assessment, completed on 11/24/10, coded the resident with a urinary drainage catheter. A hospital history and physical, dated April 13, 2011, included,			

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	but was not limited to urinary tract infection present on admission. A care plan, dated 5/7/11 addressed the problem of indwelling catheter due to urinary retention with the approach of maintain drainage bag below the level of bladder. A facility policy titled "Guidelines for Urinary Catheter Care," [no date] provided by the DON on 5/12/11 at 9:50 a.m., included, but was not limited to, "4. The urinary drainage bag should be held or positioned lower than the bladder to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. ...11. Be sure the catheter tubing and drainage bag are kept off the			

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	floor." 3.1-41(a)(2)			
F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure a safe environment was maintained for 1 of 1 resident reviewed with frequent falls in a sample of 12 identified with history of frequent falls. [Resident #24] Findings include: During initial tour on 5/5/11 at 11:45 a.m., with the Assistant Director of Nursing Services, [ADNS] Resident #24 was identified as having multiple falls, and was disoriented. The	F0323	F323Res. #24 has had fall prevention interventions evaluated with a pressure pad applied to bed/chair, alarming floor mat, scoop mattress and boxes are out of reach to prevent manipulation. Care Plan and assignment sheet have been updated to reflect current interventons.Completion Date 6/12/11All residents with fall risk interventions have the potential to be affected and therefore have been assessed to ensure proper placement of alarms and inservicing along with securement devices will ensure boxes are out of reach and unable to be manipulated as well as all careplan intervenions in place.Completion Date 6/12/11Nursing staff will be inserviced on proper alarm/box placement and clip placement to prevent manipulation.Completion Date 6/12/11Sytemic change will include adding alarm bags to house and secure the alarms.Completion Date 6/12/11DHS/Designee wil monitor 5 alarms daily for proper clasp	06/12/2011

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	nurse indicated a floor mat alarm had been in use but was defective and on hold until replaced. The nurse indicated the resident had history of unclipping tab alarms, and utilized a pressure pad alarm on bed. The resident was observed in bed with a clip alarm attached to the front of her shirt, and the alarm box hanging on the drawer pull of the bedside table, within reach of the resident, and a tab alarm behind the resident with the alarm box laying on top of the mattress not attached to the resident. The ADNS assisted the resident up from the bed, and a pressure alarm was not observed, or sounding. The resident was transferred to a wheelchair. No cushion, or pressure alarm were observed on the wheelchair.		attachment and placement of box for 30 days. 5 alarms per week thereafter for 5 months.Results of monitoring will be forwarded to QA Committee monthly for 6 months for review and quarterly thereafter.	

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	On 5/6/11 at 9:30 a.m., Resident #24 was observed propelling self in wheelchair with a tab alarm attached to the back of her shirt. The resident was leaning forward towards bed and indicated she wanted to lay down. On 5/6/11 at 9:50 a.m., Resident #24 was observed lying in bed on the left side. A tab alarm was observed clipped to the front of the resident's shirt. The alarm box was attached to the drawer pull of the bedside table, within the resident's reach. On 5/6/11 at 11:20 a.m. Resident #24 was observed in bed, awake and the clip alarm had been removed from the resident's shirt. The resident			

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	indicated she wanted to get up. On 5/10/11 at 2:00 p.m. the resident was observed in bed with a clip alarm fastened to the front of the resident's shirt. The resident was observed to be awake. On 5/11/11 at 9:20 a.m. and 10:00 a.m., the resident was observed in bed on the left side with a tab alarm attached to the front of the resident's shirt. The alarm box was fastened to the drawer pull of the bed side cabinet. The wheelchair positioned next to the resident's bed was observed with a blue and white afghan type blanket in the seat of the chair, no anti-tipper bars were observed on the chair. On 5/11/11 at 12:00 p.m. the			

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	resident was observed lying in bed on the left side with a clip alarm unfastened from the front of her shirt. The resident was attempting to get out of bed. CNA #11 entered room to assist the resident. An alarm box on a pressure pad alarm was observed on top of the mattress and was removed and attached to a pressure pad alarm on the resident's wheelchair. The resident indicated she knew how to undo that if she wanted. A blue wedge cushion was observed in the resident's chair. On 5/11/11 at 2:15 p.m. Resident #24 was observed in bed with a pressure pad alarm on the bed. The alarm box was observed within the resident's reach on the bedside table. The resident's wheelchair was not observed in the room.			

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	On 5/11/11 at 2:30 p.m., the Maintenance Supervisor was interviewed. The supervisor indicated he had just attached anti-tippers to the front and back of the resident's wheelchair. The DON was interviewed regarding the resident's falls on 5/11/11 at 9:30 a.m. The DON indicated the following regarding the resident's falls: The resident had resided on the residential unit, had repeated falls which resulted in staples to the head and after working with the resident's family the resident was transferred to the health care unit on 11/30/10. The DON during the interview indicated on 12/6/10 the			

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	resident had been in a wheelchair in the doorway of room leaned forward attempting to pick up something from the floor, fell over tipping the wheelchair over with her. The DON indicated anti-tipper bars were added to the front and back of the wheelchair at that time. The DON indicated on 12/24/10 the resident was with therapy in the therapy department started to transfer self and went down. On 12/31/10 the resident stood up from the wheelchair, the clip alarm sounded and the resident slid to the floor. On 1/24/11 the resident slid from the recliner in room and the non-skid Dycem was added to the chair. On 2/3/11 the resident stood up from the			

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	wheelchair an alarm sounded, and the resident went to her knees. At that time a wedge cushion was placed in the resident's wheelchair. On 2/19/11 the resident got out of the wheelchair. A floor mat alarm didn't sound, a pressure pad alarm sounded and the alarm box was changed on the mat alarm. The resident received a skin tear to the left forearm. On 3/7/11 the resident was found on the bathroom floor. The DON indicated the resident had gotten out of bed the pressure alarm had sounded. The DON was not sure if the mat alarm sounded. The DON indicated a scoop mattress was added at that time.			

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	On 3/22/11 the resident was found on the bathroom floor. The resident had gotten out of a chair and the clip alarm was sounding. On 4/28/11 the resident was found on the bathroom floor had gotten up from chair and the alarm had been sounding. The resident's clinical record was reviewed on 5/10/11 at 2:25 p.m. A Minimum Data Set [MDS] assessment, completed on 3/10/11 coded the resident as requiring extensive assistance of one for transfers, and had history of falls with one injury not major. A Care Area Assessment [CAA] completed on 12/12/10 indicated the triggered area of falls, had history of and			

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	potential for falls, resident impulsive at times and will attempt to get up without assistance. On a scheduled toileting program, has bed and chair alarms for safety and is at times confused related to diagnosis of dementia. A fall care plan, dated 3/4/11 addressed falls with approaches which included, but not limited to, pressure alarm bed/chair mat floor alarm beside bed, 5/4/11; anti-tippers to wheelchair, 12/6/10, scoop mattress, 12/31/10; dycem recliner, 1/24/11; pummel cushion, 4/1/11. Physician's orders were noted dated 12/2/10 for pressure pad alarm to bed and chair, 2/1/11 pressure pad floor alarm, and 1/28/11 scoop mattress to bed for safety. A telephone			

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	physician's order was noted dated 5/1/11 for hold pressure pad floor alarm till new one received. 3.1-45(a)(2)			

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F0356 SS=C	The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation and interview the facility failed to prominently display nurse staffing data for 10 of 10 days of survey; and to post up to date information for 2 of 10	F0356	F356 There were no residents affected by this deficient practice and none that were potentially affected.DHS inserviced on requirement to have daily staffing posted.Completion Date 6/1/11Posting will be in the main lobby.Completion Date 6/1/11Executive Director will review daily staffing sheet to	06/12/2011

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	days of survey. Findings include: 1. On 5/10/11 at 2 p.m., the nurse staffing data was observed to be posted on the nursing desk of the 300 hall. The staffing data was for the 100, 200, and 300 hall units. The nurse staffing data was dated 5/8/11. On 5/11/11 at 3:00 p.m., the nursing staffing data for the 100, 200, and 300 hall units was observed to be posted on the nursing desk of the 300 hall. The nursing staffing data was dated 5/8/11. Interview of the Administrator and Director of Nursing on 5/11/11 at 4 p.m. indicated the nursing staff data was only		ensure the requirements are met and the posting is present. QA rounds monthly will include the staffing be posted and current with all required data and reported to committee for 12 months.	

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	posted on the 300 hall of the nursing facility. The Administrator indicated the staffing should be posted to current date. 3.1-13(i)(4)			
F0368 SS=C	Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. Based on interview and record	F0368	F368Resident #1, 4, 10, 24, 25, 26, 27, 31 and 32 suffered no ill	06/12/2011

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	review the facility failed to offer snacks at bedtime daily for 9 of 11 residents identified not receiving dietary prepared snack in a sample of 12 . This had the potential to affect 43 of 45 residents. (Resident #1, Resident #10, Resident #24, Resident #32, Resident #31, Resident #26, Resident #25, Resident #27, Resident #4). Findings include: 1. During group interview with alert and oriented residents on 5/5/11 at 11 a.m., Residents #1, #10, #24, #32, #31, #26, #25, #27, and #4, indicated they were not offered a bedtime snack, but if they requested one it would be provided. Interview of Dietary Aide #27 on 5/11/11 at 2:15 p.m.		effects or weight loss from the alleged deficient practice and in the future will be offered a bedtime snack and acceptance/refusal will be documented.Completion Date 6/12/11All residents have the potential to be affected by the alleged deficient practice and will be offered a bedtime snack with acceptance/refusal documented.Completion Date 6/12/11Systemic change includes dietary and nursing inserviced regarding snack expectations, documentation of acceptance/refusal and content as well as variety for all diet types to be offered and stock on unit for availability of snack at any timeCompletion Date 6/12/11Director of Food Service/Designee will monitor bedtime snack contents daily for 2 weeks and weekly thereafter. DHS will monitor bedtime snack consumption and interview 2 residents daily for 30 days, then 1 time weekly for 30 days, then 1 time monthly for 6 months. Executive Director/designee will audit compliance through review of audits and resident council interviews monthly.Results of all audits and resident council minutes will be forwarded to QA Committee monthly for 6 months and quarterly thereafter for review and further recommendations.	

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	indicated dietary prepared residents' with specific plan for bedtime snack, a snack at bedtime. The Dietary Aide indicated the prepared snacks were delivered to the nursing stations and then nursing passed the bedtime snacks. The Dietary Aide also indicated dietary stocked the "pub" area for staff to obtain bedtime snacks for residents. Interview of evening shift CNA #26 on 5/11/11 at 2:20 p.m. indicated that residents' with orders for bedtime snacks were provided prepared snacks by dietary and nursing then passed the snacks. The CNA also indicated that if other residents requested a bedtime snack then they would get them something from the "pub" area. The CNA indicated the staff			

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	did not go door to door to offer bedtime snacks. Review of list titled "HS Snack List " on 5/13/11 at 10:30 a.m. indicated only two residents in the Health center received prepared bedtime snacks. Review of current facility policy and procedure titled " Guidelines for Between Meal Snacks" dated December 2010 on 5/13/11 at 10:30 a.m. indicated "...1. Snacks such as fresh fruit, coffee, and juice are available at all times. Other snack items are also available at all times upon request...5. Knock and gain permission to enter the resident's room. 6. Verify the identity of the resident. 7. Ask the resident if he/she wishes to be served a snack. Inform the resident of			

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	the snack choices. If none of the choices are acceptable ask if there is something else they would like and provide it if available...9. If the resident is asleep document as such and return at a later time and offer again if awake...." 3.1-26(e)			

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F0441 SS=K	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, interview, and record review a. the facility failed to practice	F0441	F 441Residents #11, #2, #42, #27, #25, #10, and #9 were all place in private accomodations and rooms deep cleaned utilizing a 1:10 Bleach Solution. A cart was placed inside the door of the	06/12/2011

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	standard precautions to protect and prevent widespread nosocomial infections in that hand hygiene, linen handling, contact isolation were not maintained to prevent contamination as well as incomplete tracking of infections for 4 of 4 residents in a sample of 12 and 3 of 3 residents in a supplemental sample of 4 being treated for Clostridium difficile infections [Residents #11, #2, #42, #27, #25, #10, and #9]; and co-horting of residents with Clostridium difficile infections [C-diff] was not maintained to prevent contamination for 1 of 5 residents in a sample of 12 and 1 of 1 resident in a supplemental sample of 4 without the diagnosis of C-diff sharing rooms with infected residents [Residents #26 and		residents room to contain isolation gowns and gloves for donning prior to providing care. The cart also contains personal medical equipment i.e. stethoscope, blood pressure, cuff, thermometer, etc... to only be used on the resident in isolation. All staff were inserviced on c-diff and isolation precautions.Completed 5/6/11All residents have the potential to be affected by the deficient practice therefore all residents were reviewed for a diagnosis of c-diff and though inservicing, initiating proper infection control technique, and utililization of a 1:10 Bleach solution we are preventing recurrance of this deficient practice.Completion Date 5/6/11All staff were inserviced on C-Diff and proper infection control, isolation technique and proper cleaning agents to utilize during isolation.Completion Date 5/6/11Systemic change includes the usage of 1:10 Bleach water when cleaning of resident rooms with C-Dif, placement of an isolation cart to be used on residents on isolation, Communication Boards placed in Housekeeping and Dietary Dept. for communcating residents in isolation, Private accomodations when warranted when a resident is in isolation.Completion Date 5/6/11The Infection Control Log will be updated daily with any new infections, all lab results and physician orders will be reviewed	

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	#28]. Disinfectant and cleaning products utilized through out the facility, including isolation rooms, were not effective for C-Diff. b. The facility failed to ensure techniques were utilized to prevent contamination for 1 of 1 resident reviewed in a sample of 12 observed receiving dressing treatment to open areas. [Resident #25]. This deficient practice had the potential to affect all 45 residents of the facility. This deficient practice resulted in Immediate Jeopardy. The immediate jeopardy was identified on 5/6/11 and began on 5/6/11. The Executive Director and Director of Nursing were notified of the Immediate Jeopardy on 5/6/11. The Immediate Jeopardy was removed on 5/10/11, but the		5 days per week during morning stand up to identify any new infections, the Infection Control Log will be reviewed monthly by the QA Committee and necessary action plans will be initiated for any trends. An audit tool will be developed and implemented to audit care of residents on isolation to assure protocol is being followed with results being reviewed by the QA Committee. The tool will be utilized on each shift for 30 days, then 3 times per week for 30 days, then monthly for 90 days. QA Committee will review for further recommendations.	

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	facility remained out of compliance at the level of patter, no actual harm with potential for more than minimal harm that is not immediate jeopardy for continued monitoring of nursing and housekeeping staff and inservice training for compliance with infection control/isolation techniques and procedures; education of visitors of residents with C-diff. regarding precautions; monthly review of infection control logs by the quality assurance committee; and auditing each shift, each wing by the charge nurse to verify protocol is followed for a minimum of 30 days. Findings include:			

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	a1. During interview of LPN #15, on 5/4/11 at 12:05 p.m. the LPN identified five residents, Resident #'s 2, 9, 10, 11 and 42 residing on the 100 and 300 units, as having c-diff. a2. On 5/5/11 at 10:00 a.m., LPN #16 identified Residents' #27 and #25 on the 200 hall unit with C-diff. Magnetic signs posted on the door frames were noted of "STOP SEE NURSE FOR INSTRUCTIONS." a3. During initial tour on 5/4/11 at 11:45 a.m., with the Assistant Director of Health Services [ADHS] Resident #25 was identified as returning from the hospital with four open areas, alert and oriented, had an indwelling Foley catheter. The resident was			

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	observed in the room on a specialty air alternating mattress. Upon entering the room on 5/5/11 at 10:05 a.m., CNA #5 was observed providing care to Resident #25. Soiled linens were observed on the carpeted floor. The CNA indicated the resident had just had a loose bowl movement kind of greenish and clear. While wearing gloves, the CNA bathed and dressed the resident's upper body. The CNA was observed to lean across the resident's body, and blue, air loss mattress cover while providing the care. The CNA was not wearing a gown or protective barrier covering. The CNA was observed to step on the linens on the floor at the end of the bed while moving			

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	back and forth around bed providing care. The CNA dressed the resident without wearing gloves, opened the privacy curtain, moved the resident's wheelchair entered the bathroom and washed hands. A pink wash basin utilized for the bathing, was observed on the resident's over bed table, and a towel utilized to dry the resident was placed on the table. Other items observed on the table next to the basin and towel were a box of snack crackers, a vase, a canned drink, container of wet wipes, and a box of body powder. After completion of the resident's care, the CNA, without wearing gloves or gown, picked the soiled linens up from the floor and bagged them, touching against uniform during the process. The bags			

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	were then discarded into cardboard boxes lined with red biohazard bags located in the bathroom. The CNA then washed hands and exited room. CNA#5 returned to the room with CNA #6. Both CNAs washed hands and donned gloves. The staff assisted the resident to sit on the side of the bed, and lifted the resident under the arms to transfer into a wheelchair. Gowns were not utilized while in close contact with the resident. On 5/6/11 at 11:10 a.m., RN #7 was observed to provide wound care treatments to the resident. During the treatment, while in close contact with resident, leaning against the resident's bed, the RN was observed to wear gloves, and not to wear a			

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	barrier, protective covering. After completing the wound treatments the RN removed the gloves, picked up the bed control from the floor and placed it next to the resident, adjusted the pillow, bagged linens and trash without gloves, opened the bathroom door and discarded the linens/trash into the biohazard boxes in the bathroom which were observed to be filled beyond capacity with refuse mounded above the tops of the containers. Resident #25's clinical record was reviewed on 5/5/11 at 11:25 a.m. The resident's admission date was noted of 11/12/10. The resident's diagnoses included, but were not limited to breast cancer, and pathological hip fracture. Documentation was noted on a			

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	hospital history and physical report dated 4/13/11 of admitted to hospital with diarrhea, septic shock, pneumonia, and urinary tract infection. A hospital inter-agency transfer form, dated 5/2/11, indicated the resident had been treated for right lower lobe pneumonia, and was in transmission precautions, contact isolation for C-Diff. A hospital discharge note, dated 5/2/11 indicated the resident's C-diff diarrhea was improved. RN #7 was interviewed on 5/6/11 at 9:30 a.m. and indicated the resident returned to the facility on 5/2/11. RN #7 indicated gloves are worn for contact precautions and gowns were only utilized for MRSA [Methicillin resistant			

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	Staphylococcus aureus] infections. The RN indicated visitors who ask are instructed to wash hands when they go into a room with contact isolation and wash hands, before they leave. A physician's order was noted dated 5/2/11 for Vancomycin 250 milligrams [mg] by mouth four times daily times seven more days for C-diff. A physician's order was noted dated 5/4/11 for contact isolation. On 5/6/11 at 3:30 p.m. RN #21 indicated contact isolation is started if a positive C-diff culture is reported or if resident is on oral Vancomycin. Documentation on the May Medication Administration Record reviewed on 5/6/11,was noted of the Vancomycin being			

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	administered May 3, 4, 5, and 6. Documentation on the form titled "CORP-Resident BM Description-NEW" provided by the Assistant Director of Health Services, on 5/6/11 at 10:50 a.m., contained documentation of the resident having loose stools on 5/3/11 and 5/4/11; soft stools on 5/4, and two times on 5/5/11. Documentation on the record for dates of 5/6-9/11 documented three formed stools and five soft stools. A plan of care which addressed the diagnosis of C-Diff and contact isolation was lacking. a4. During initial tour on 5/4/11 at 11:45 a.m. with the ADHS, Resident #26 was identified as			

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	a new Cerebral Vascular Accident [CVA] and was on peritoneal dialysis. The nurse indicated the dialysis is performed during the night. The resident's dialysis supplies and machine were observed in the room, just on the other side of the privacy curtain in a room shared with Resident #25, diagnosed with C-diff. Resident #26's clinical record was reviewed on 5/5/11 at 2:15 p.m. an admission date was noted of 4/8/11 with readmission date of 4/27/11. A physician's order was noted 4/27/11 for Dialysis 2.5 % [per cent] 10 L [liters] every hour of sleep start at 8:00 p.m. off in a.m. A diagnosis of C-diff was not noted. On 5/6/11 the resident was discharged to the hospital with lethargy.			

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	a5. During initial tour on 5/4/11 at 11:45 a.m. with the ADHS, Resident #27 was observed in bed with a Foley catheter. The resident had been recently readmitted from the hospital had decreased oxygen saturation rates, was confused, on oxygen at 6 liters and had a PIC line [central intravenous access]. The resident's call button was observed on the carpeted floor. The ADHS picked up the call button and placed it on the resident's bed within reach. On 5/5/11 at 1:00 p.m., CNA #5 was observed coming from the Resident's bathroom wearing gloves, carrying a bedpan and placing it in a plastic bag, opened the resident's closet door, and			

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	placed the bagged bedpan on top of personal items in the resident's closet. The CNA indicated the resident had a watery dark green stool and had three stools this shift. A protective barrier covering was not being worn. A pink, unbagged wash basin was observed on top of the resident's personal items in the closet. A red, isolation plastic bag was observed on the bathroom floor, underneath the sink. On 5/5/11 at 3:10 p.m., CNA #20 was observed to enter Resident #27's room with an electronic blood pressure monitor on a wheeled stand, a wrist blood pressure cuff, pulse oximeter, and temporal thermometer. The CNA was observed not to wear gloves or			

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	gown to protect uniform while in close contact with the resident. The resident's blood pressure, oxygen saturation, pulse, and temperature were taken with the devices. The CNA exited the room with the equipment, utilized hand gel and went down the hall. The CNA returned to the equipment and was observed going back into the room, to check the resident's roommate's vital signs. On 5/6/11 at 9:50 a.m., CNAs #18 and #19 were observed to provide a bed bath to Resident #27. The CNAs were observed to be wearing gait belts around their uniforms, to wear gloves, and to not be wearing a protective barrier covering. The CNAs' uniforms were observed to come into contact with the			

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	resident, and resident's bed during the care. After completion of the care, CNA #19 was observed to rinse the wash basin in the bathroom sink, placed it in a bag and put it in the resident's closet on top of personal items. The CNA was interviewed at that time as to how the resident's bedpan was cleansed and indicated she usually rinses it out with the shower sprayer. Resident #27's clinical record was reviewed on 5/5/11 at 3:20 p.m. A nursing note indicated the resident was readmitted from the hospital on 5/3/11 and a physician's order was noted dated 5/3/11 for Flagyl 250 mg two tabs by mouth for three days and an order was noted dated 5/4/11 for oral			

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	Vancomycin 5 ml [milliliters] by mouth daily. A hospital gastroenterologist report, dated 4/25/11 indicated the resident had c-diff colitis and currently was on Flagyl. Documentation on the form titled "Resident BM Description" was noted of the resident having three loose stools on 5/5/11. A care plan was noted dated 5/7/11 which addressed c-diff and to follow contact isolation precautions. a6. During initial tour on 5/4/11 at 11:45 a.m. with the ADHS, Resident #28 was observed in bed on a speciality air mattress. The Resident was identified as having an open area on the middle of the back			

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	and diagnosis of cancer. The resident's wife was observed to be feeding the resident. The resident shared the room with Resident #27, with diagnosis of c-diff. Resident #28's clinical record was reviewed on 5/9/11 at 11:50 a.m. The resident's diagnoses included, but was not limited to left hip and humerus fractures, metastic prostate cancer, and insulin dependent diabetes mellatus. A diagnosis of c-diff was not noted. a7. On 5/5/11 at 1 p.m., Resident #42's private room was observed to have sign posted inside of the door frame indicating to see the nurse for instructions. A red barrel with red plastic lining was observed inside of the resident's bathroom as well as box with red plastic bags. RN #7 was observed to assist the resident with stand by assist to the bathroom. The resident utilized a walker. The RN was observed			

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	to not wear gloves or gown. The resident was observed to pull down her incontinent brief and pants. The resident voided. The RN was observed to apply new incontinent brief while the resident was seated on toilet. The RN was observed to apply gloves. The resident attempted to cleanse self with toilet paper. Bowel movement was noted on the toilet paper the resident was using. The resident stood up touching the grab bar and the walker. The RN cleansed the resident's buttocks with disposable cleansing cloths. Without changing the contaminated gloves, the RN picked up tube of "calazime" barrier cream, opened the tube, and applied the cream to the resident's buttocks. The RN then returned the tube of cream to the back of the sink. The RN then removed her gloves and assisted the resident in pulling up her pants. The RN and the resident washed their hands. The resident was transferred to the wheelchair. The RN was observed to pick up and move the walker (the walker previously touched by resident). The RN was observed to exit the room. On 5/6/11 at 10:20 a.m., Resident #42 was observed to be sitting on toilet in bathroom. CNA #5 was observed to apply			

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	gloves and removed the resident's brief which was wet from urine. The CNA did not wear gown. The CNA removed gloves and washed hands. The CNA assisted the resident with a new brief. The resident cleansed self with toilet paper. The resident and CNA were observed to wash hands. Interview of CNA #5 on 5/6/11 at 10:30 a.m. indicated Resident #42 was in contact isolation. The CNA indicated gloves were to be worn when a resident is in contact isolation. The CNA was unable to indicate whether or not the resident had been having loose stools or not. Review of the clinical record of Resident #42 indicated the resident was readmitted to the health center from the hospital on 3/29/11 with diagnosis which included but was not limited to Clostridium Difficile colitis. The history and physical dated 3/18/11 on admission to the hospital indicated the resident had some diarrhea/loose stools for the			

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	past few days and the resident was not eating and drinking well with diffuse lower quadrant abdominal pain. A lab result for Clostridium Difficile toxin A and B of the stool dated 3/21/11 indicated Clostridium Difficile toxin A and/or B were detected. The admission orders dated 3/29/11 included Vancocin [antibiotic utilized to treat Clostridium Difficile] 250 milligram (mg) every six hours for two weeks then Vancocin 250 mg twice daily for two weeks then discontinue. Nursing notes dated 3/29/11 at 2:45 p.m. indicated the resident was readmitted to the facility with isolation precautions due to Clostridium Difficile.			

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	The resident was readmitted to the hospital on 4/18/11 with diagnosis of sepsis and pneumonia. The resident was readmitted to the facility on 4/26/11 with the following admission orders: Vancomycin 250 mg/5 milliliters four times daily for 10 days for Clostridium Difficile. The resident completed the Vancomycin treatment on 5/6/11. The "Resident BM Description" dated 5/7/11 and 5/8/11 indicated the resident continued to have "loose" stools. The resident's current plan of care indicated the problem of infection as exhibited by positive Clostridium Difficile			

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	dated 4/7/11 with approaches that included but were not limited to follow other appropriate precautions -contact; monitor lab/diagnostics as ordered and report abnormal findings to MD; and Administer/monitor effectiveness of treatments as ordered. Interview of Resident #42's family on 5/9/11 at 12:15 p.m. indicated the family had not been given information regarding Clostridium Difficile until this past weekend of 5/7/11 and 5/8/11. a8. Resident #2 was observed on 5/5/11 at 2 p.m. to be transferred from the wheelchair to the bed by CNA #1 and CNA #4. A sign was noted posted on outside of resident's door "to			

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	see nurse for instructions." A gait belt was noted to be utilized for transfer by the CNAs. A red barrel was observed in the resident's bathroom. The resident resided in private room. The CNAs were observed to wear gloves during the transfer. No isolation gowns were worn by the staff. Staff were observed to assist the resident with positioning the resident's feet into the bed. The CNAs were observed to remove their gloves and wash their hands. The gait belt was removed from the room after the transfer. Interview of CNA #4 on 5/5/11 at 2:10 p.m. indicated the resident usually had one loose stool a day. The CNA indicated the resident was worried when			

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	stool was loose that it was "C Diff" again. The CNA indicated the resident had been toileted earlier and requires extensive assistance. The CNA indicated the resident was in contact isolation and that gloves were to be worn during care. Review of the clinical record on 5/5/11 at 1:30 p.m. indicated the resident was readmitted to the facility on 2/14/11 without diagnosis of Clostridium Difficile. A laboratory result dated 2/25/11 indicated a stool culture for Clostridium Difficile Toxin A and B was negative for the Clostridium Difficile Toxin A and B. A laboratory result dated 3/14/11 indicated a stool			

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	culture as positive for Clostridium Difficile Toxin A and/or B. A physician's order was noted dated 3/15/11 of Flagyl 500 milligram one three times daily for 10 days for Clostridium Difficile. A physician's order dated 3/18/11 was noted of Contact isolation for Clostridium Difficile and may discontinued when stools are negative X2. A laboratory result dated 3/28/11 for stool indicated negative for Clostridium Difficile Toxin A and B. A laboratory result dated 3/30/11 indicated a stool culture as positive for Clostridium Difficile Toxin A			

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	and/or B. A physician's order dated 3/31/11 was noted of Vancomycin 250 mg one by mouth four times daily for 14 days for Clostridium Difficile. A laboratory result dated 4/18/11 for stool indicated negative for Clostridium Difficile Toxin A and B. A laboratory result dated 4/23/11 for stool indicated Clostridium Difficile Toxin A and/or B detected. A physician order was noted dated 4/24/11 of Vancomycin 250 mg one by mouth four times daily for 2 weeks then Vancomycin 250 mg twice daily for 2 weeks then Vancomycin 250 mg one every			

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	day for one week and then discontinue- Recheck stool for Clostridium Difficile after Vancomycin treatment. The "Resident BM Description" dated 5/6/11-5/9/11 at 1:30 p.m. indicated a loose stool on 5/7/11. The most recent Minimum Data Set (MDS) assessment dated 2/21/11 indicated the resident as cognitively intact; always incontinent of bowel; frequently incontinent of bladder; and requiring extensive assistant with toilet use, hygiene and bathing. The resident's current plan of care identified the problem infection as exhibited by positive for Clostridium			

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	Difficile dated 3/16/11. The approaches included but were not limited to follow other appropriate precautions-contact; administer/monitor effectiveness of medications as ordered; Administer/monitor effectiveness of treatments as ordered; and hold colace until further notice due to Clostridium Difficile. Review of the infection control logs on 5/6/11 at 11:20 a.m. did not indicate Resident #2 with Clostridium Difficile infection on 3/14/11. Interview of the Director of Nursing on 5/6/11 at 11:45 a.m. indicated she was unsure why Resident #2 was not reflected on the infection control logging.			

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	a9. During initial tour on 5/4/11 which began at 11:30 a.m., with LPN #14, a sign was noted on the outside of a resident room, indicating " STOP SEE NURSE FOR INSTRUCTIONS." LPN #14 indicated Resident #11 had Clostridium difficile (c-diff). On 5/5/11 at 3:55 p.m., Resident # 11 was observed to be toileted by CNAs #9 and # 10. The staff were observed to wear gloves. Isolation gowns were observed not to be worn. The resident was noted to wear disposable brief. A posting was noted on outside of door to indicate to "see nurse for instructions." Red barrel and box lined with red plastic bags were observed in the resident bathroom.			

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	Interview of CNA #9 on 5/5/11 at 3:55 p.m. indicated the resident #11 was in contact isolation and the gloves were needed when caring for the resident. The CNA indicated the resident continued to have diarrhea. Review of the clinical record of Resident #11 on 5/5/11 at 12:40 p.m. indicated the resident was admitted to the facility on 4/25/11 with diagnosis which included but was not limited to Clostridium Difficile colitis. A physician's order was noted dated 4/25/11 for contact isolation. A physician's order dated 4/25/11 was noted for Flagyl 500 milligram [antifungal] every 8 hours for 2 weeks and			

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	then obtain stool specimens. "Infection Assessment and Review" dated 4/26/11 indicated proper infection control techniques by staff had been observed/monitored; isolation equipment were available; and equipment used on residents with like symptoms had been properly cleaned and disinfected. "Resident BM Description" dated 4/29- 5/6/11 indicated the resident continued to have loose stools with total of 7. The resident's current plan of care identified the problem of infection as exhibited by pneumonia and Clostridium Difficile dated 5/6/11. The approaches included but were not limited to follow other			

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	appropriate precautions i.e. contact isolation; and administer/monitor effectiveness of treatments as ordered. Interview of LPN #24 on 5/5/11 at 11:30 a.m. indicated Resident #11 required assistance of 1 and/or 2 during transfers and hygiene. The resident was also identified with confusion at times. a10. On 5/5/11 at 11:30 a.m., CNA #'s 1 and 4 provided incontinence care to Resident #9. CNA #1, while wearing gloves, cleansed loose bowel movement from the resident. Without changing the gloves the CNA placed a clean brief on the resident, touched the			

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	resident's top sheet, pillow and side rail. CNA #1 and #4 assisted with the repositioning and cleansing of the resident. Neither CNA wore a gown over their uniform. Both CNAs were observed during care to lean up against the mattress. Resident #9's clinical record was reviewed on 5/5/11 at 10:50 a.m. An admission date was noted of 4/21/11. An admission order, dated 4/21/11, indicated the resident was to be on "Vancomycin" (antibiotic) due to c-diff. A May 2011 MAR (medication administration record)			

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	indicated the resident received the Vancomycin through the a.m. dose on the 5th. A plan of care, dated 5/3/11, indicated the resident with a c-diff infection. An approach of, but not limited to, was noted of "Contact" precautions. Review of a form titled "Resident BM Description", documentation indicated the resident had three loose stools on 5/6/11, two loose stools on 5/7/11, two loose stools on 5/8/11, and one loose stool on 5/9/11. A physician's order was noted, dated 5/8/11, indicating the resident was to be started on "Flagyl 500 mg (2 tablets 1250 mg) R/T [related to] loose stools" along with "Start			

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	Vancomycin 5 ml qid [four times a day] X [times] 14 days R/T [related to] loose stools." a11. On 5/6/11 at 10:40 a.m., CNA #11 entered Resident #10's room. The CNA opened the resident's closet, removed clothing, touched the resident's wheelchair and overbed table. Without washing hands, the CNA left the resident's room and went down the hall, opened the linen closet and removed a towel and washcloth. The CNA then went back into the resident's room and provided incontinence care to Resident #10. The CNA did not wear a gown over his uniform. While providing the care, the CNA leaned up against the resident's bed. While wearing gloves, the CNA cleansed loose bowel movement from the resident.			

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	Without changing gloves, the CNA picked up the resident's urinal, opened the bathroom door, flushed the toilet, touched the resident's privacy curtain and placed a clean brief on the resident. Resident #10's clinical record was reviewed on 5/5/11 at 12:45 p.m. An original admission date was noted of 3/25/11, with a readmission date of 4/4/11. A nursing note, dated 3/29/11, indicated the resident was sent to the emergency room for respiratory problems. The nursing notes indicated the resident returned on 4/4/11. A physician telephone order was noted, dated 4/10/11,			

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	indicating "Obtain stool specimen related to frequent mucus foul smelling stool, send to [Lab] for testing c-diff." A laboratory report was noted, dated 4/11/11, indicating "clostridium difficile toxin A and/or B detected." A physician's telephone order, dated 4/11/11, indicated the resident was to receive "Flagyl (anti-fungal) 500 mg one BID [twice daily] X [times] three weeks." A May 2011 MAR [medication administration record] indicated the resident received the Flagyl through May 1, 2011. A physician's telephone order was noted, indicating "Obtain 2			

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	negative stool specimen [after] flagyl therapy." A laboratory form, dated 5/4/11, indicated the resident was "negative for Clostridium difficile Toxin A and B". Review of form titled "Resident BM Description", documentation indicated the resident had a loose stool on 4/29/11, 5/4/11, 5/5/11, and 5/8/11. a12. During review of the infection control logs, provided by the DON on 5/6/11 at 11:20 a.m., Resident #'s 9 and 10 were not on the April 2011 logs. The DON was interviewed on 5/6/11 at 11:45 a.m. The DON indicated Residents #9 and #10 were not on the April 2011 infection log			

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	and was unable to indicate why the residents were not on the infection control logs. a13. On 5/6/11, at 11 a.m., Housekeeping staff #13 was observed to exit Resident #9's room. During interview of Housekeeper #13 on 5/6/11 at 11 a.m., the housekeeper indicated he was unaware of any special precautions other than wearing gloves while cleaning the resident's room. The housekeeper indicated if any resident was identified with MRSA (methicillin resistant staph aureus) they would have to wear gowns. The housekeeper indicated that he had not been made aware of any residents requiring special precautions other than gloves.			

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	The housekeeper indicated, Virex was the disinfectant used on hard surfaces including the bathroom sink and cabinets, tables, chair arms ect. that was used for the residents' rooms. The housekeeper indicated the residents' bathrooms are mopped daily and the mop heads are changed every third bathroom. The housekeeper indicated the carpet in the residents' rooms were vacuumed every day, but were only spot cleaned if needed. During interview of the Maintenance/Environmental Supervisor on 5/6/11 at 12:20 p.m., the supervisor was unsure if the disinfectant was effective against the c-diff. The supervisor indicated the			

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	carpets in the resident rooms were spot cleaned as needed with a crystallized product type of cleaner. The supervisor indicated they try to cleanse the carpets quarterly with a cleaner titled "Krud Kutter." During review of the manufacturer's information concerning "Virex" received from the Maintenance/Environmental Supervisor on 5/6/11 at 12:25 p.m., documentation was lacking to indicate if the disinfectant was effective against c-diff. During interview of the Maintenance/ Environmental Supervisor on 5/6/11 at 3:15 p.m., the supervisor indicated "Virex" did not kill c-diff.			

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	During review of the products "KRUD KUTTER" and "iCapsol Encapsulating Interim Cleaning Chemical" received from the Maintenance/Housekeeping supervisor on 5/9/11 at 10:30 a.m., information to identify the product was a disinfectant was lacking. Review of the facility policy titled "Precautions Categories" received on 5/6/11 at 11:10 a.m., documentation was noted, under "Contact Precaution" indicating examples of, but not limited to, infections requiring Contact Precautions, was diarrhea associated with Clostridium difficile. Documentation indicated under "Resident Placement" "Individual requiring Contact			

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	Precautions should not be charted with someone who has indwelling tubes, catheters, or open wounds." Documentation indicated "clean, non-sterile gloves should be worn when entering the room. Gloves should be changed after having contact with infective material that may contain high concentrations of microorganisms (fecal material, wound drainage)" and "A clean, non-sterile gown should be worn when entering the room if: a. It is anticipated that clothing will have substantial contact with an actively infected resident, environmental surfaces, or items in the resident room. b. The actively infected individual is incontinent, has diarrhea, an ileostomy, a colostomy or wound drainage not contained			

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	by a dressing. Clothing should not come in contact with potentially contaminated environmental surfaces after removal of the gown. Documentation indicated under "Resident care equipment" "Disposable or dedicated use of non-critical resident care equipment items such as stethoscope, sphygmomanometer, bedside commode or electronic rectal thermometer to a single resident with an active infection to avoid sharing between residents is preferable. If use of common items is unavoidable, items should be adequately cleaned and disinfected before use for another resident." The facility policy titled "Surveillance Process," [no			

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	date] provided by the Executive Director on 5/9/11 at 2:25 p.m., included, but was not limited to: Infections surveillance is designed to accomplish several goals: 1. Enable the facility to quickly identify clusters and/or significant increases in the occurrence of infection. 2. Observe and evaluate the effectiveness of nosocomial infection prevention techniques of resident care delivery. A. Data Collection 1. Walking rounds provide the Infection Control Practitioner (IC) the chance, while visiting a unit, to talk with staff, observe residents, etc. Opportunities for a brief, on-the-spot infection control inservice may occur: ...Any resident who has had a culture should be evaluated for potential			

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	infection, regardless of the result. ...The Infection Control Committee provides guidance, recommendations to address problems suggested by the facility's nosocomial infection rate. Implement the recommended changes and evaluate their effectiveness. ..." b. On 5/6/11 RN #7 was observed to provide dressing treatments to open areas on Resident #25's back and left hip. While wearing gloves the RN removed dressings, dated 5/3/11 from the back and left hip. The RN applied normal saline to a gauze 4 by 4 dressing and cleansed the open area on the resident's back, observed with a yellow colored center. With the same gloves, the nurse utilized a second gauze and cleansed an open			

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	area on the resident's left hip. With the same gloves on the nurse dried the back, then hip, then removed the gloves. The nurse donned another pair of gloves, dated two duoderm dressings, applied a dressing to the back area, then hip. RN #7 assisted the resident in repositioning after completing the treatment, then removed the gloves. A facility policy titled "General Guidelines for Dressing Changes," dated December 2009, provided by the DON on 5/13/11 at 10:35 a.m., included, but was not limited to, "Purpose: To ensure measures that will promote and maintain good skin integrity while maintaining standard measures that will minimize/control contamination. ...Procedure:			

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	6. Put on first pair of disposable gloves. 7. Remove soiled dressing and discard in plastic bag. 8. Dispose of gloves in plastic bag. 9. Wash hands with soap and water. 10. Put on second pair of disposable gloves. 11. Follow doctors recommendations for treatment. 12. Apply dressing and secure with tape when done with treatment. ...14. Remove gloves and discard with all unused supplies in plastic bag. 15. Wash hands with soap and water. ..." An Immediate Jeopardy was identified on 5/6/11 at 4:30 p.m. The IJ began on 5/6/11 when the facility failed to practice standard precautions to protect and prevent widespread nosocomial infections. The Immediate Jeopardy was			

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	removed on 5/10/11 at 5:00 p.m. when through observations, interviews, and record review, it was determined that the facility had implemented the plan of action to remove the Immediate Jeopardy and that the steps taken removed the immediacy of the problem. Through observations, residents without C-diff. were not sharing rooms with residents infected. Isolation stations were set up outside of infected resident rooms and staff were observed entering isolation rooms wearing protective coverings to provide care. Through in-service log reviews and interviews, nursing and housekeeping staffs were in-serviced prior to starting work on handwashing and c-diff management.			

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	Housekeeping chemicals were observed to be changed to products effective for C-diff. Education of visitors to infected residents was implemented. Even though the facility remained out of compliance at a level of pattern, no actual harm with potential for more than minimal harm that was not immediate jeopardy. 3.1-18(l)			
R0409	(d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview the facility failed to	R0409	R409Resident #4 was given a TB test.Completion Date 6/12/11All residential residents have the potential to be affected by the	06/12/2011

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	ensure tuberculin skin tests were completed annually for 1 of 2 residents requiring annual tuberculin skin tests in a sample of 4. (Resident #4) Findings include: 1. Review of the clinical record of Resident #4 on 5/12/11 at 3 p.m. indicated the resident was admitted to the facility on 1/12/09. The resident received tuberculin skin test on 2/1/09. A tuberculin skin test since 2/1/09 was lacking. Interview of the Administrator on 5/13/11 at 10:20 a.m. indicated Resident #4 had not received an annual tuberculin skin test and should have.		alleged deficient practice and therefore have been verified that a current TB test has been done and through alteration in procedures and inservicing will ensure that tuberculin tests are performed before or at time of admission and annually.Completion Date 6/12/11.Systemic change will include adding the most current PPD administration date to he monthly level of care log. Licesed nurses will be inserviced on new procedure.Completion Date 6/12/11.AL Manager/Designee will audit all residential records quarterly for current documentation of administration of tuberculin tests.Results of audits will be forwarded to QA for review monthly for 6 months and quarterly thereafter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155772	A. BUILDING 00 B. WING	05/13/2011

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R0410	(e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview the facility failed to ensure residents admitted to the facility without documented negative tuberculin skin test in the preceding twelve months were provided tuberculin skin testing that employed the second step method for 2 of 2 residents admitted since June of 2010 in a sample of 4. (Resident #2 and Resident #3).	R0410	R410Resident #2 was given a 2 step TB test.Completion Date 6/12/11Resident #3 was given a 2 step TB test.Completion Date 6/12/11All residential residents have the potential to be affected by the alleged deficient practice and therefore have been verified that a current TB test including those that require 2 step has been done and through alteration in procedures and inservicing will ensure that 2 step tuberculin tests are performed before or at time of admission and annually.Completion Date 6/12/11Systemic change will include adding the most current PPD administration date to the monthly level of care log. For the	06/12/2011

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	Findings include: 1. Review of the clinical record of Resident # 3 on 5/12/11 at 3:35 p.m. indicated the resident had been admitted to the facility on 1/10/11. The resident received a tuberculin test 1/10/11 with a negative result and a second step tuberculin test was lacking. Interview of the Administrator on 5/13/11 at 10:20 a.m. indicated Resident #3 did not receive a second step tuberculin test and should have. 2. Review of the clinical record of Resident # 2 on 5/12/11 at 2:20 p.m. indicated the resident had been admitted to the facility on 6/18/10. The resident received a tuberculin		residents that are newly admitted we will keep the immunization record with the MAR until the 2 step process is complete. Licensed nurses will be inserviced on new procedure.Completion Date 6/12/11AL Manager/designee wil audit all residential records upon admission and until the 2 step process is complete, then quarterly to ensure proper administration and documentation of tuberculin tests occurs.Results of audits will be forwarded to QA for review monthly for 6 months then quarterly thereafter.	

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	test on 4/10/10 prior to admission, with a negative result. A second step tuberculin skin test was lacking. Interview of the Director of Nursing on 5/12/11 at 3:50 p.m. indicated the resident did not receive a second step tuberculin skin test on admission.			